STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #KS00061034 and #KS00060587.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 1	F 272		

This REQUIREMENT is not met as evidenced by:
The facility had a census of 42 residents with 3 sampled for review.

Based on observation, interview, and record review, the facility failed to complete a comprehensive assessment which included summary information regarding additional assessments performed for 1 of 3 sampled residents. Resident #101's 10/23/12 Behavioral Symptom CAA (care area assessment) summary lacked information related to the resident exit seeking behaviors identified in the 10/23/12 Significant Change MDS (minimum data set) assessment.

Findings included:

- Resident #101's 10/23/12 Significant Change MDS (minimum data set) assessment revealed the resident had moderately impaired cognition. The resident had signs and symptoms of delirium which included inattention and disorganized thinking. The assessment indicated the resident had physical behavioral symptoms directed toward others and other behavioral symptoms not directed toward others during 1-3 days of the assessment period. The assessment also indicated the resident had wandering behaviors that placed the resident at significant risk of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 2	F 272		

getting to a potentially dangerous place. Resident #101 required extensive assistance of 2 persons for bed mobility, transfers, and toilet use. He/she used a wheelchair for mobility.

Resident #101's 10/23/12 Behavioral Symptom CAA (care area assessment) summary revealed the resident's physical condition had declined related to his/her diagnosis of cancer. The CAA summary described the resident's "erratic" behaviors, however, failed to address the resident's wandering/exit seeking behavior and recent elopement and fall on 10/12/12.

Resident #101's updated 10/30/12 nursing care plan lacked identification of the resident's wandering and exit-seeking behaviors or direction to staff related to prevention of elopement.

Nurses' notes on 10/10/12 at 8:00 p.m. revealed resident #101 went to the west door, opened the door and had his/her wheelchair halfway out of the door when staff responded to the sounding door alarm.

According to a facility investigation on 10/12/12 at 6:15 a.m., resident #101 entered a code into the keypad by the west exit door and exited independently in a wheelchair, tipped over in the wheelchair, and fell at the bottom of the 3 steps by the exit. The resident had a "code alert" bracelet (device to alert staff when the resident approached an exit door) on his/her ankle which initiated the blue strobe light inside of the facility. No audible alarm sounded since the resident entered the correct code into the keypad.

Resident #101's 10/12/12 Elopement Risk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 3	F 272		

Assessment identified the resident as at risk for elopement as evidenced by recent attempts to leave the facility and successfully exited the facility on 10/12/12.

Nurses' notes on 10/23/12 at 11:20 p.m. revealed the resident attempted to leave the facility at the west entrance again. The notes further stated the resident had the door open and headed out of the door when staff responded to the alarm.

The facility's 10/07 Resident Elopement Prevention Policy and Procedure stated residents who exhibited or developed wandering will be assessed and the "care plan team will recommend a specfic plan of care for implementation within seven days of the incident".

During an observation on 11/15/12 at 7:55 a.m. resident #101 sat in a wheelchair in the hall way by the dining area and slowly self-propelled to the dining room for breakfast. He/she had a "code alert" bracelet on his/her ankle.

During an interview on 11/14/12 at 2:49 p.m. administrative nurse B confirmed resident #101's nursing care plan lacked information related to his/her wandering behavioral symptoms. Administrative nurse B stated he/she had not considered exit seeking as a behavior and confirmed the CAA summary lacked consideration of the resident's wandering/exit seeking behavior and recent elopement.

The facility failed to complete a comprehensive assessment which included summary information in resident #101's 10/23/12 CAA related to behavioral symptoms of wandering as identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 4 in the 10/23/12 Significant Change MDS.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility had a census of 42 residents with 3 sampled for review. Based on observation, interview, and record review, the facility failed to revise 2 of 3 sampled residents' nursing care plans. (#101 and #102) Findings included: - Resident #101's 10/23/12 Significant Change	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 5	F 280		

MDS (minimum data set) assessment revealed the resident had moderately impaired cognition. The resident had signs and symptoms of delirium which included inattention and disorganized thinking. Resident #101 required extensive assistance of 2 persons for bed mobility, transfers, and toilet use. He/she used a wheelchair for mobility. According to the assessment, the resident had 2 or more non-injury falls and 1 minor injury fall since the prior assessment.

Resident #101's 10/23/12 Falls CAA (care area assessment) summary indicated the resident had an overall decline in the past month affecting his/her cognition, balance, ability to stand independently, and his/her awareness of safety. The summary indicated the resident fell 6 times in the past month, one fall with a minor injury. The resident attempted to stand on his/her own and required frequent 1:1 attention from staff.

Resident #101's 10/30/12 nursing care plan included the following interventions for fall preventions:

* I am on 30 minute checks by staff and I want to be free of fall related injuries.
* I have a pressure pad alarm on the floor by my bed to alert staff and a tabs monitor to place in my wheelchair and on my bed. I have removed these and hid them in the past so please check for their presence.
* I need help from 2 staff with my sit to stand lift.
* Only put resident to bed when he/she seemed sleepy (revised on 11/9/12).
* Sit at nurses' station in wheelchair and provided activity or food/drink (revised on 11/14/12).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 6	F 280		

Resident #101's Fall Risk Assessment on 8/14/12 revealed a score of 14 and on 10/23/12 revealed a score of 22, both scores indicated the resident had a "high risk" for falls.

A physical assessment form completed following a fall on 10/11/12 revealed the resident had an unwitnessed fall when staff found the resident laying on his/her left side beside his/her bed. An intervention noted on the assessment form stated, "Resident brought to nurses station while awake".

A physical assessment form completed following a fall on 10/18/12 revealed the resident had a witnessed fall with the intervention section of the form blank. Review of the nurses notes for 10/18/12 lacked documentation of the fall. Review of the nursing care plan lacked revision following the fall on 10/18/12.

A physical assessment form completed following a fall witness fall on 10/23/12 when staff lowered the resident to the floor revealed this intervention, "[resident] kept at nurses station with gadgets to keep busy".

The facility's 3/1312 revised Fall Assessment policy stated, "Following a fall, complete the Physical Assessment Form". The Physical Assessment Form included an area to document interventions implemented.

During an observation on 11/15/12 at 7:55 a.m. resident #101 sat in a wheelchair in the hall way by the dining area and slowly self-propelled to the dining room for breakfast. He/she had a tab alarm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 7	F 280		

in place as well as a pressure alarm and anti-roll bars on the wheelchair.

During an interview on 11/15/12 at 10:18 a.m., direct care staff D stated resident #101 had 2 alarms while in the wheelchair, a pressure alarm and a tab alarm. He/she further stated staff used a sit to stand lift for the resident for transfers.

An interview on 11/19/12 at 11:00 a.m. with licensed nurse C confirmed staff used a tab unit as well as a pressure alarm for resident #101 when he/she sat in the wheelchair. He/she further stated when a resident sustained a fall, licensed staff assessed the resident, evaluated the circumstances of the fall,, and should revise the resident's nursing care plan to prevent future falls.

The facility failed to revise resident #101's nursing care plan with interventions to prevent future falls. The care plan lacked revision following the 10/18/12 fall and staff repeated the intervention to keep the resident at the nurses station on 10/11/12, 10/23/12, and 11/14/12. The 10/30/12 nursing care plan also failed to reflect the current use of 2 alarms while the resident sat in the wheelchair.

- Resident #102's 7/31/12 Quarterly MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 11 which indicated moderately impaired cognition and exhibited wandering behaviors during 1-3 days of the assessment period. The resident transferred and walked independently. He/she had no functional limitations in range of motion and used a walker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8	F 280		

for mobility. The resident had 1 non-injury fall since the last assessment.

Resident #102's 10/16/12 Annual MDS assessment revealed the resident had a BIMS score of 7 which indicated severe cognitive impairment without wandering behaviors. The assessment indicated the resident required limited assistance with walking in his/her room/corridor, transferred independently, and used a walker for mobility. He/she had 2 or more non-injury falls since the prior assessment.

Resident #102's 10/16/12 nursing care plan included this intervention, "I have a tabs alarm for my chair and one for my bed. I take them off myself but please attach them to me if you see them off." The nursing care plan lacked interventions to address the resident's wandering behaviors identified on the 7/31/12 MDS and use of a "code alert" bracelet (device to alert staff when the resident approached an exit door).

According to the "code alert" (device to alert staff when the resident approached an exit door) log for resident #102, the resident wore a "code alert" device since 2/15/12.

The facility's 10/07 Resident Elopement Prevention Policy and Procedure stated residents who exhibited or developed wandering will be assessed and the "care plan team will recommend a specfic plan of care for implementation within seven days of the incident".

During an observation on 11/14/12 at 1:40 p.m. resident #102 ambulated independently with a walker to the west activity room door and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9 attempted to exit. An audible alarm sounded as the resident pushed on the door. The resident wore a "code alert" bracelet on his/her right ankle. The blue strobe light illuminated in the corridor. Direct care staff E responded to the alarms, checked the "code alert" panel in the hallway and ran to the west activity room door. Direct care staff E re-set the "code alert" bracelet after intervening and redirected the resident away from the exit door. During an interview on 10/15/12 at 10:18 a.m., direct care staff D identified resident #102 as an elopement risk and stated he/she wore a "code alert" bracelet on the ankle. Direct care staff D further stated the resident ambulated independently in his/her room. He/she stated they no longer used a tab alarm on the resident as the resident's condition had improved. An interview on 11/14/12 at 2:49 p.m. with administrative nurse B confirmed resident #102's nursing care plan lacked identification of the resident's wandering and exit-seeking behaviors or direction to staff related to prevention of elopement. Administrative nurse B also stated the care plan needed revision to reflect that staff no longer used a tab alarm for resident #102 when he/she sat in his/her chair. The facility failed to revise resident #101's nursing care plan with interventions to prevent future falls. Resident #102's nursing care plan lacked revision related to the use of a tab alarm and his/her risk for elopement.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 42 residents with 3 sampled for review. Based on observation, interview, and record review, the facility failed to provide 2 of 3 sampled residents with the necessary care and services to attain or maintain the highest practicable physical and mental well-being in accordance with the comprehensive assessment and plan of care (thorough nursing assessments including neurological checks after unwitnessed falls) for residents #101 and #103. Findings included: - Resident #101's 10/23/12 Significant Change MDS (minimum data set) assessment revealed the resident had moderately impaired cognition. The resident had signs and symptoms of delirium which included inattention and disorganized thinking. Resident #101 required extensive assistance of 2 persons for bed mobility, transfers, and toilet use. He/she used a wheelchair for mobility. The assessment indicated the resident had 2 or more falls with no injury and 1 minor injury fall since the prior assessment.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11	F 309		

Resident #101's 10/23/12 Falls CAA (care area assessment) summary indicated the resident had an overall decline in the past month affecting his/her cognition, balance, ability to stand independently, and his/her awareness of safety. The summary indicated the resident fell 6 times in the past month, one fall with a minor injury. The resident attempted to stand on his/her own and required frequent 1:1 attention from staff.

Resident #101's 10/30/12 nursing care plan included the following interventions for fall preventions:

* I am on 30 minute checks by staff and I want to be free of fall related injuries.
* I have a pressure pad alarm on the floor by my bed to alert staff and a tabs monitor to place in my wheelchair and on my bed. I have removed these and hid them in the past so please check for their presence.
* I need help from 2 staff with my sit to stand lift.
* Only put resident to bed when he/she seemed sleepy (revised on 11/9/12).
* Sit at nurses' station in wheelchair and provided activity or food/drink (revised on 11/14/12).

The physical assessment form completed following an unwitnessed fall on 9/24/12 revealed a neurological assessment done at the time of the initial assessment after the fall, with no follow-up neurological evaluations. According the nurses' notes on 9/24/12 at 4:20 a.m., staff found resident #101 on the floor after he/she attempted to use his/her walker to get to the closet for clean pants.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12	F 309		

Review of the completed physical assessment form following an unwitnessed fall on 10/11/12 revealed a lack of completion of neurological checks after the fall. According to the nurses' notes on 10/11/12, staff found the resident on the floor laying beside his/her bed. After obtaining vital signs and completion of an assessment, staff transferred the resident to a wheelchair and brought the resident to the nurses' station.

The completed physical assessment form following an unwitnessed fall on 11/14/12 revealed a lack of documentation of the resident's blood pressure, pulse, and respirations. According to the nurses notes staff responded to an alarm and found resident #101 on a landing mat on his/her knees . The notes indicated "vital signs" taken without documentation of the results. Review of the Vital Signs Record revealed no documentation of vital signs for 11/14/12.

The facility's 3/13/12 Fall Assessment policy directed staff to complete the physical assessment form, neurological assessment, monitor blood pressure, temperature, pulse, respirations, and oxygen saturation levels.

During an observation on 11/15/12 at 7:55 a.m. resident #101 sat in a wheelchair in the hall way by the dining area and slowly self-propelled to the dining room for breakfast. He/she remained alert, but did not respond verbally. The resident had a tab alarm in place as well as a pressure alarm and anti-roll bars on the wheelchair.

During an interview on 11/19/12 at 11:06 a.m. licensed nurse C confirmed a nursing assessment with vital signs should be completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13	F 309		

when a resident falls and neurological checks should be performed if no one witnessed the resident's fall and the resident lacked the cognitive ability to say if he/she hit their head during the fall.

The facility failed to proved resident #101 with necessary care and services to attain or maintain the highest practicable physical and mental well-being when licensed nursing staff failed to complete thorough nursing assessments including neurological checks following falls.

- Resident #103's 9/4/12 Significant Change MDS (minimum data set) assessment revealed the resident had severely impaired cognition, required extensive assistance of 2 persons for transfers, walking in room, and toilet use. The resident had no falls since the prior assessment.

Resident #103's 9/4/12 Fall CAA (care area assessment) summary identified the resident as "high risk" for falls. The summary indicated the resident had a fall on 8/9/12 with no injury when the resident sat on the floor during a transfer to the toilet by staff. The resident had an appointment with his/her physician and received a new order for a medication for atrial fibrillation (irregular heart rhythm). The resident required assistance of 2 staff due to his/her instability, imbalance, and decreased cognition.

Resident #103's 9/11/12 nursing care plan for falls included the following interventions:

* I require 2 staff and a gait belt for transfers and use a wheelchair for mobility.
* Every 15 minutes checks this shift (updated on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 14 9/14/12) * Tabs monitor (updated 10/30/12) The completed physical assessment form following an unwitnessed fall on 10/30/12 revealed neurological checks marked as "not applicable". According to the nurses' notes on 10/30/12 revealed staff found resident #103 by the west door. After assessment and vital signs, staff assisted the resident to his/her bathroom. The facility's 3/13/12 Fall Assessment policy directed staff to complete the physical assessment form, neurological assessment, monitor blood pressure, temperature, pulse, respirations, and oxygen saturation levels. During an observation on 11/14/12 at 4:28 p.m., resident #103 sat in a wheelchair and self-propelled in the facility hallway. The resident wore rubber soled slippers and had a tab alarm on while in the wheelchair. During an interview on 11/19/12 at 11:06 a.m. licensed nurse C confirmed a nursing assessment with vital signs should be completed when a resident falls and neurological checks should be performed if no one witnessed the resident's fall and the resident lacked the cognitive ability to say if he/she hit their head during the fall. The facility failed to provide resident #103 with necessary care and services to attain or maintain the highest practicable physical and mental well-being when licensed nursing staff failed to complete thorough nursing assessments including neurological checks following falls.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 42 residents with 3 sampled for review. The facility identified 11 residents as "at risk" for elopement. Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accident hazards as possible for 11 residents identified as at risk for elopement when the facility failed to adequately monitor the functioning of exit door alarms and the "code alert" wander device system. Resident #101 eloped from the facility on 10/12/12 and sustained a fall with a minor injury. Findings included: - Resident #101's 8/14/12 Quarterly MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 9 which indicated moderately impaired cognition. The resident had no wandering behaviors and required extensive assistance of 2 persons for bed mobility, transfers, and toilet use. He/she had functional	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16	F 323		

limitations in range of motion in both lower extremities and used a wheelchair for mobility. The resident had 1 minor injury fall since the prior assessment.

Resident #101's 10/23/12 Significant Change MDS assessment revealed the resident had moderately impaired cognition. The resident had signs and symptoms of delirium which included inattention and disorganized thinking. The assessment indicated the resident had physical behavioral symptoms directed toward others and other behavioral symptoms not directed toward others during 1-3 days of the assessment period. The assessment also indicated the resident had wandering behaviors that placed the resident at significant risk of getting to a potentially dangerous place. Resident #101 required extensive assistance of 2 persons for bed mobility, transfers, and toilet use. He/she used a wheelchair for mobility.

Resident #101's 10/23/12 Behavioral Symptom CAA (care area assessment) summary revealed the resident's physical condition had declined related to his/her diagnosis of cancer. The CAA summary described the resident's "erratic" behaviors, however, failed to address the resident's wandering/exit seeking behaviors and recent elopement and fall on 10/12/12.

Resident #101's 10/23/12 Falls CAA (care area assessment) summary indicated the resident had an overall decline in the past month affecting his/her cognition, balance, ability to stand independently, and his/her awareness of safety. The summary indicated the resident fell 6 times in the past month, one fall with a minor injury. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17	F 323		

resident attempted to stand on his/her own and required frequent 1:1 attention from staff.

Resident #101's 10/30/12 nursing care plan included the following interventions for fall preventions:

* I am on 30 minute checks by staff and I want to be free of fall related injuries.
* I have a pressure pad alarm on the floor by my bed to alert staff and a tabs monitor to place in my wheelchair and on my bed. I have removed these and hid them in the past so please check for their presence.
* I need help from 2 staff with my sit to stand lift.
* Only put resident to bed when he/she seemed sleepy (revised on 11/9/12).
* Sit at nurses' station in wheelchair and provided activity or food/drink (revised on 11/14/12).

Resident #101's updated 10/30/12 nursing care plan lacked identification of the resident's wandering and exit-seeking behaviors or direction to staff related to prevention of elopement.

Resident #101's Fall Risk Assessment on 8/14/12 revealed a score of 14 and on 10/23/12 revealed a score of 22, both scores indicated the resident had a "high risk" for falls.

Resident #101's 10/12/12 Elopement Risk Assessment identified the resident as "at risk" for elopement as evidenced by recent attempts to leave the facility and successfully exited the facility on 10/12/12.

Resident #101 had a "code alert" bracelet (device to alert staff when the resident approached an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18	F 323		

exit door) since 7/19/12. When a resident with a "code alert" bracelet approached an exit door, the doors should lock down with activation of blue strobe lights in the facility hallways. Panels located in the hallways identified the resident that activated the alert as well as the exit door involved.

Nurses' notes on 10/10/12 at 8:00 p.m. revealed resident #101 went to the west door, opened the door and had his/her wheelchair halfway out of the door when staff responded to the sounding door alarm. Apparently, the "code alert" bracelet activated the blue light but failed to lock down the west door.

According to a facility investigation on 10/12/12 at 6:15 a.m., resident #101 entered a code into the keypad by the west exit door and exited independently in a wheelchair, tipped over in the wheelchair, and fell at the bottom of the 3 steps by the exit. The resident had a "code alert" bracelet (device to alert staff when the resident approached an exit door) on his/her ankle which activated the blue strobe light inside of the facility at 6:13 a.m. when the resident approached the exit door. No audible alarm sounded since the resident entered the correct code into the keypad. Direct care staff F reported hearing a faint beeping sound when going to the west exit desk and followed the sound outside the west exit door and found the resident. The resident had a pressure alarm in the wheelchair that made the beeping sound. Direct care staff F discovered the resident at 6:23 a.m. at the bottom of 3 stairs located at the exit. Video surveillance verified the resident entered the code into the keypad and the times of activation of the "code alert" system and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19	F 323		

when staff discovered the resident. At the time of the elopement, the ambient temperature registered at 39.9 degrees F. (Fahrenheit). The resident sustained a 1.3 cm (centimeter) abrasion to the back of his/her head. According to video surveillance, the resident remained outside of the building for a period of 8 minutes from the time the resident entered the code into the keypad and when direct care staff F discovered the resident. Corrective action by the facility included changing the door alarm codes.

Nurses' notes on 10/23/12 at 11:20 p.m. revealed the resident attempted to leave the facility at the west entrance again. The notes further stated the resident had the door open and headed out of the door when staff responded to the alarm. Apparently, the doors failed to lock down when the resident approached the west exit door wearing a "code alert" bracelet.

The facility's 2/28/11 Wander Device Check Policy and Procedure stated, "Wander devices will be checked by Medical Records Clerk Monday through Friday. In his/her absence, testing will be completed by Resident Services Coordinator, MDS nurse, SSD [Social Services Designee], or DON [Director of Nursing]. The door test procedure also stated, "As you approach the door you should hear the doors lock. Attempt to push against the door handle (without keying in the code), the door should be locked. Document findings in the Code Alert notebook. Report any non functional door alarms to Maintenance."

Review of resident #101's "code alert" log (documentation of checking for proper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20	F 323		

functioning), revealed administrative staff G checked the resident's device on 11/1/12, 11/5/12, 11/6/12, and 11/7/12. Administrative nurse A checked the device on 11/14/12. A period of 7 days occurred without facility staff checking the device.

The facility's revised October 2007 Resident Elopement Prevention Policy and Procedure stated, "The door alarm system will be tested weekly. Testing will include alarm functions and staff's response to the alarms."

Review of the Code Alert Check Log that listed the exit doors revealed a period of time from 9/14/12 until 10/1/12 with no documentation of checking the exit doors, a period of 18 days.

During an observation on 11/14/12 at 1:56 p.m., the middle west exit door failed to alarm or open after pushing on the door handle for over 15 seconds. A sign on the door stated, "Push until alarm sounds. Door can be opened in 15 seconds."

During an observation on 11/14/12 at 1:59 p.m., the south west exit door also failed to alarm or open after pushing on the door handle for over 15 seconds. A sign on the door stated, "Push until alarm sounds. Door can be opened in 15 seconds."

On 11/14/12 at 2:13 p.m. maintenance staff H adjusted the middle west and south west exit doors so the doors alarmed and opened after 15 seconds of pressure on the door handles.

On 11/14/12 at 4:00 p.m. administrative nurse A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21	F 323		

checked all of the exit doors and "code alert" system and confirmed they functioned properly.

During an observation on 11/15/12 at 7:55 a.m. resident #101 sat in a wheelchair in the hall way by the dining area and slowly self-propelled to the dining room for breakfast. He/she had a "code alert" bracelet on his/her ankle.

During an interview on 11/14/12 at 1:50 p.m. administrative nurse A identified 11 residents in the facility that wore "code alert" bracelets and identified them as "at risk" for elopement.

During an interview on 11/14/12 at 3:40 p.m., administrative staff G stated he/she had the responsibility of checking the door alarms and "code alert" system. Administrative staff G stated he/she checked the doors and "code alert" system on Mondays through Thursdays. Staff G stated he/she remained absent from work on 9/14/12 until 10/1/12 and did not know if anyone checked the doors during his/her absence.

An interview on 11/15/12 at 10:18 a.m. direct care staff D stated resident #101 wore a "code alert" bracelet on his/her ankle and had a history of "challenging" the exit doors. Direct care staff D stated the blue strobe light activated when a resident with a "code alert" bracelet approached an exit. He/she further stated that a panel in the hallways indicated which resident activated the light and the door involved. He/she stated staff should then go to the exit door involved and locate the resident.

During an interview on 11/20/12 at 7:50 a.m. administrative nurse A confirmed when the "code

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	C 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVE COUNTY MEDICAL CENTER LTCU	PO BOX 129 QUINTER, KS 67752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22 alert" device activated the blue strobe, the exit door should lock down. He/she further stated they had some problems with the doors locking down a few weeks ago and maintenance staff adjusted the doors so they locked down properly. Administrative nurse A confirmed when he/she checked the "code alert" system on 11/14/12 at 4:00 p.m., the doors locked down when the system activated. The facility failed to ensure the resident environment remained free of accident hazards as possible for 11 residents identified as at risk for elopement when the facility failed to adequately monitor the functioning of exit door alarms and the "code alert" wander device system. Resident #101 eloped from the facility on 10/12/12 and sustained a fall with minor injury.	F 323		